SAMHSA-HRSA
Center for Integrated Health Solutions

Region 5 Meeting, Fall 2012

HIT Projects Discussion

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HIT Supplement Grant – Next Steps re: Grant

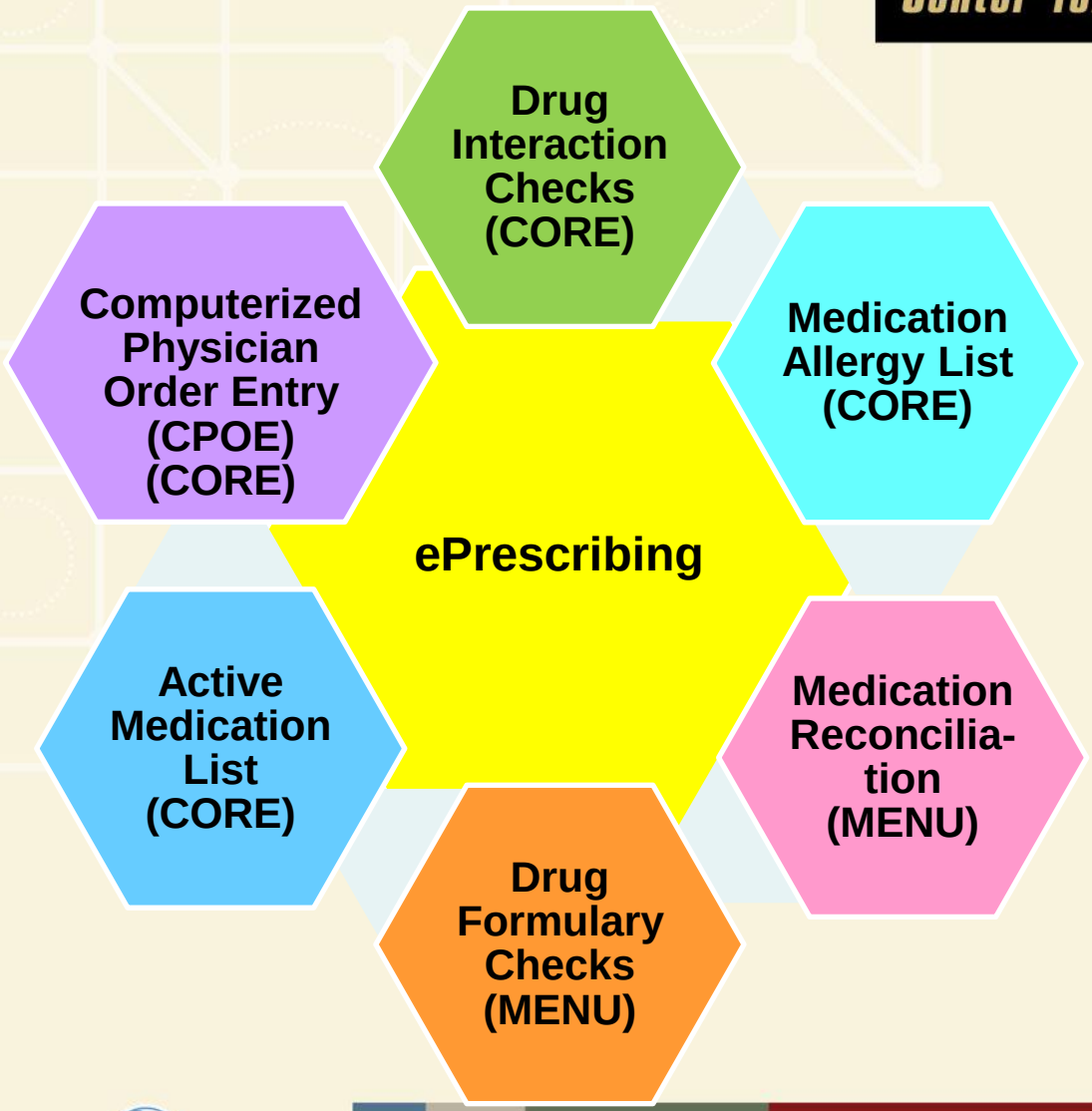
- Attend final Technical Assistance Webinars on meeting the grant requirements – ask questions
- Submit 4th Quarter report to your GPO on progress as usual 10/31 (following the format for the 1st, 2nd and 3rd Quarter reporting)
- Follow pending guidance from SAMHSA on the Final Report (due 90 days after end of grant period)

Next Steps re: Meaningful Use

- Why “Meaningful Use” is here and where it is headed
  - Two sentinel studies highlighted the need for improvements in the safety and quality of American health care (1,2)
  - Meaningful Use of patient data seeks to answer the question “How can we make improvements in the “safety and quality of American health care?” (3)
- Stage 1 Meaningful Use – January 2011, 2012, 2013
  Stage 2 Meaningful Use – January 2014, 2015 (4)

Safety and Quality Issues– Medications

- Adverse drug events (ADEs) cause more than 770,000 injuries and deaths each year…At least three-quarters of these ADEs are caused by systemic errors" (5)



Stage 1 MU, Domain 1: Improve Quality, Safety, Efficiency…

5 Core and 2 Menu Objectives Targeted to Reducing ADEs

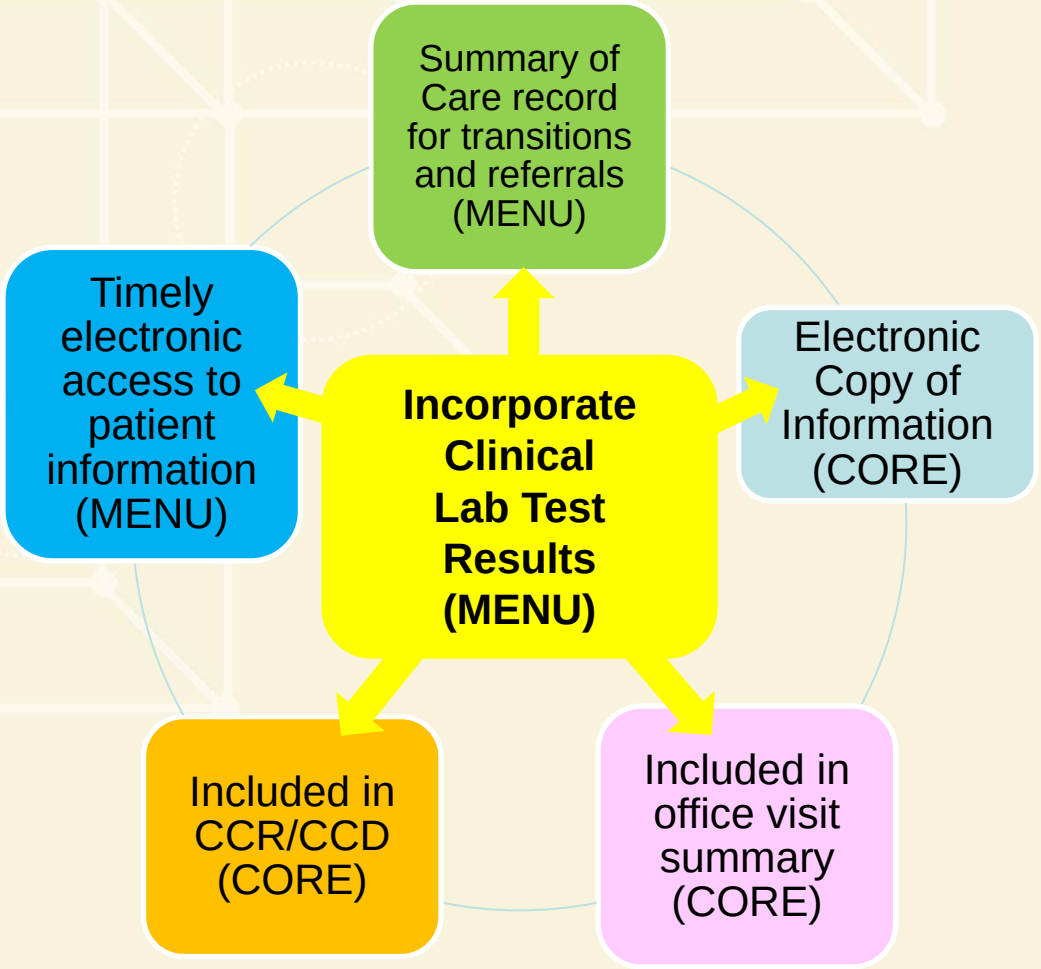
Medications information included in patient summaries

Stage 2 NPRM re: Medication (6)

- "Use CPOE" for 60% of medication orders (currently 30%)
- "ePrescribing" for more than 50% (currently 40%)
- "Medication reconciliation" becomes a Core Objective, at more than 80% of transitions of care (currently a Menu Objective at 50%)
- "Drug formulary checks" becomes a Core Objective
- "Drug-drug/drug-allergy checks" refined (false positive interaction rules)

Safety and Quality Issues - Diagnostic Test Results

- Over 200,000 clinical (certified) laboratories …conduct more than 7 billion tests per year (8)
- Accounts for only about 2.3% of annual health care costs in the United States BUT influences the majority of patient care decisions (8)
- Practices that…optimize use of laboratory testing can have a substantial effect on patient safety, clinical decision making about treatments and interventions, health outcomes, and costs (8)



Stage 1 MU, Domain 1: Improve Quality, Safety, Efficiency…

1 Menu Objective

Included in patient summary information (3 Core, 2 Menu)

Stage 2 NPRM re: Diagnostic Test Results (6)

- "Incorporate lab results as structured data" becomes a Core Objective (Currently a Menu Objective) 40% stays the same

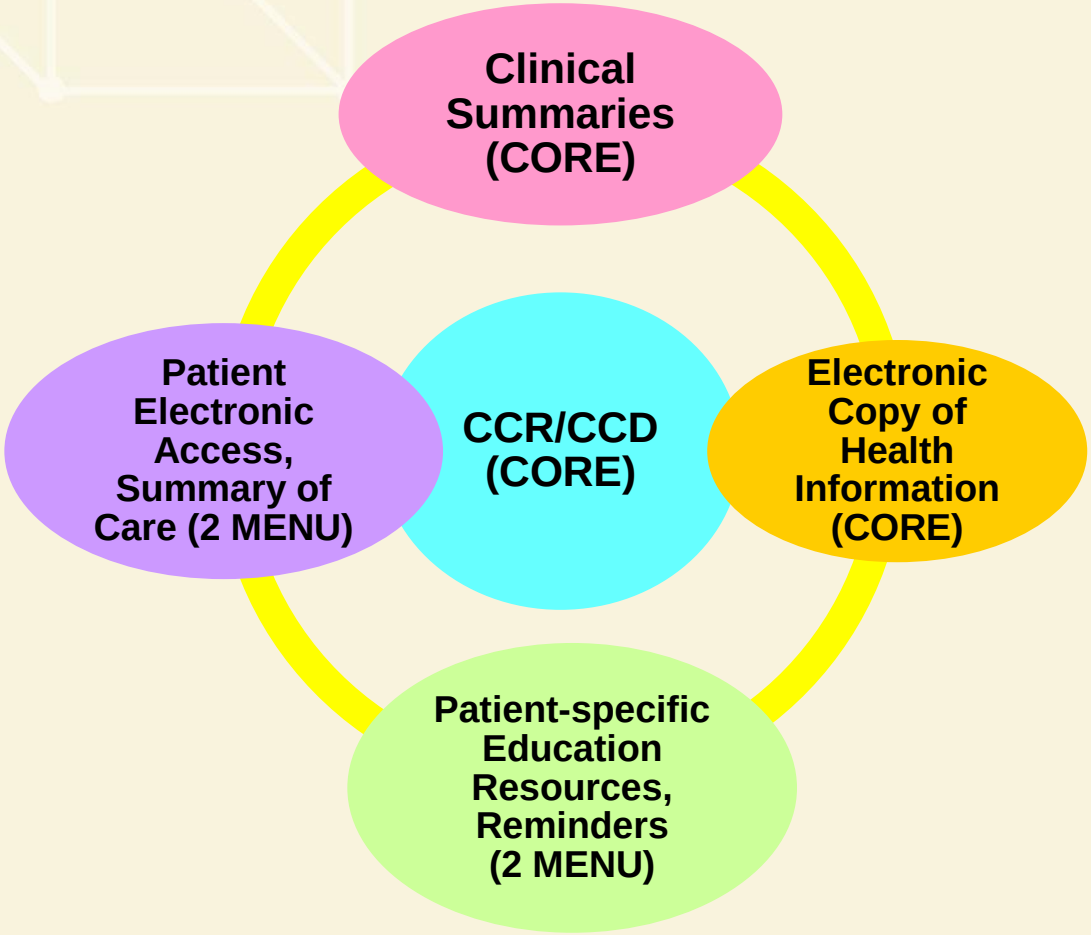
- CPOE includes lab orders and radiology (currently medication only)

Safety and Quality Issues
Patient Engagement, Exchanging Patient Information

- Two consistent pain points: lack of communication and lack of coordination (8)
- Results in medical errors, testing and treatment duplication, misdiagnoses (8)
- Institute of Medicine (IOM) called for the coordination of patient care across patient conditions, services, and sites of care over periods of time (2)
- One of the ten rules for redesign of the health care system (2)

Stage 1 MU, Domain 2: Engage Patients and Families

3 Core and 4 Menu Objectives Targeted to Engaging Patients and Families, Improving Communication and Coordination

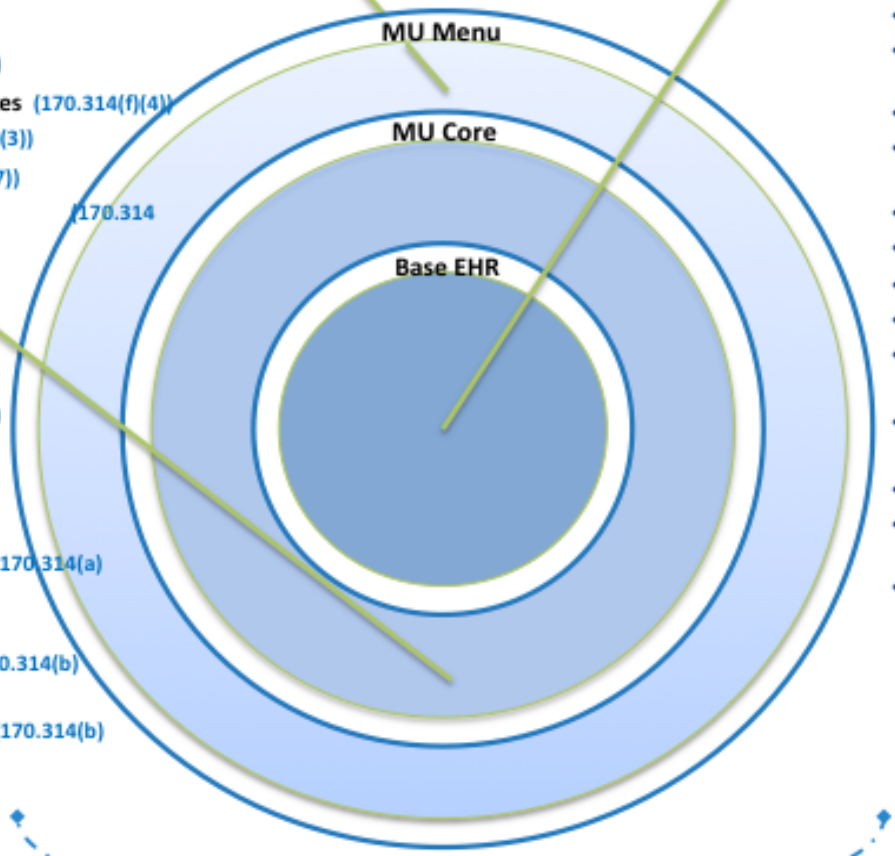


Stage 2 NPRM – Communication and Coordination (6)

- Changes to Existing Core Objective Measures
  - "Demographics" for 80% of patients (currently 50%)
  - CCD/CCR bidirectional connection to at least 1 HIE and connection to a provider directory, or connections with three external providers in primary referral networks
- Moved from Menu to Core Objective List
  - "Advance Directives"
  - "Patient reminders"
  - "Timely electronic access" (increased from 10% to 20%)
  - "Summary of Care Record" (increased from 50% to 80%)

Stage 2 NPRM – Communication and Coordination (6)

- New Requirements
  - New Core Objective 10% of patients provided list of care team members
  - New Core Objective 30% of patient visits will require an electronic note
  - New Core Objective for Secure Online Messaging
  - New Core Objective 20% of patient preference for communication is recorded
  - Multiple new patient engagement requirements – electronic self-management tools, interfaces to PHRs, patient reporting of care experience online, patient-generated data incorporated into EHRS – under refinement



2014 Certification Criteria associated with MU Menu Stage 2:

- Imaging (170.314(a)(12))
- Family health history (170.314(a)(13))
- Transmission to public health agencies (170.314(f)(4))
- Public health surveillance (170.314(f)(3))
- Cancer case information (170.314(f)(7))
- Transmission to cancer registries (170.314(f)(8))

2014 Certification Criteria associated with MU Core Stage 2:

- Drug formulary checks (170.314(a)(10))
- Smoking status (170.314(a)(11))
- Patient lists (170.314(a)(14))
- Patient reminders (170.314(a)(15))
- Patient-specific education resources (170.314(a)(16))
- eRx (170.314(b)(3))
- Clinical information reconciliation (170.314(b)(4))
- Incorporate lab test & results/values (170.314(b)(5))
- Clinical summaries (170.314(e)(2))
- Secure messaging (170.314(e)(3))
- Immunization information (170.314(f)(1))
- Transmission to immunization registries (170.314(f)(2))

2014 Certification Criteria associated with a Base EHR:

- CPOE (170.314(a)(1))
- Drug-drug, drug-allergy interaction checks (170.314(a)(2))
- Demographics (170.314(a)(3))
- Vital signs, BMI, & growth charts (170.314(a)(4))
- Problem list (170.314(a)(5))
- Medication list (170.314(a)(6))
- Medication allergy list (170.314(a)(7))
- Clinical decision support (170.314(a)(8))
- Transitions of Care – incorporate summary care record (170.314(b)(1))
- Transitions of Care – create & transmit summary care record (170.314(b)(2))
- Clinical quality measures (170.314(c)(1)-(2))
- View, download, & transmit to 3rd Party (170.314(e)(1))
- Privacy and Security CC:
  - Authentication, access control, & authorization (170.314(d)(1))
  - Auditable events & tamper resistance (170.314(d)(2))
  - Audit report(s) (170.314(d)(3))
  - Amendments (170.314(d)(4))
  - Automatic log-off (170.314(d)(5))
  - Emergency access (170.314(d)(6))
  - Encryption of data at rest (170.314(d)(7))
  - Integrity (170.314(d)(8))
  - Accounting of disclosures (optional) (170.314(d)(9))

2014 Certification Criteria associated with calculation & reporting:

- Automated numerator recording (170.314(g)(1))
- Automated measure calculation (170.314(g)(2))
- Non-%-based measure use report (170.314(g)(3))
- Clinical quality measures (170.314(c)(3))

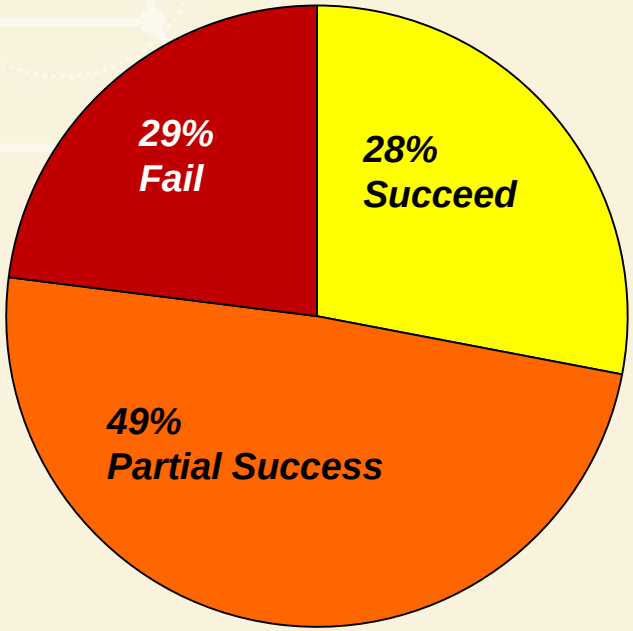
Additional 2014 Certification Criteria proposed:

- Electronic Notes (170.314(a)(9)
- Safety-enhanced design (170.314(g)(4))

Adoption of Meaningful Use

- Primary Care (9)
  - Using a certified Complete EHRS (meets "Meaningful Use" criteria)
    - 27% of FQHCs
    - 20% of Hospitals
    - 55% physicians (practices with 11+ physicians = 86%)
    - Nearly ½ physicians plan to purchase within the next year
- Behavioral Health (10)
  - Using a certified Complete EHRS (meets "Meaningful Use" criteria)
    - 2% by end of 2011, 5% by end of 2012 = 7% Community Mental Health and Addictions Treatment Organizations
    - "Upfront financial costs" most significant barrier

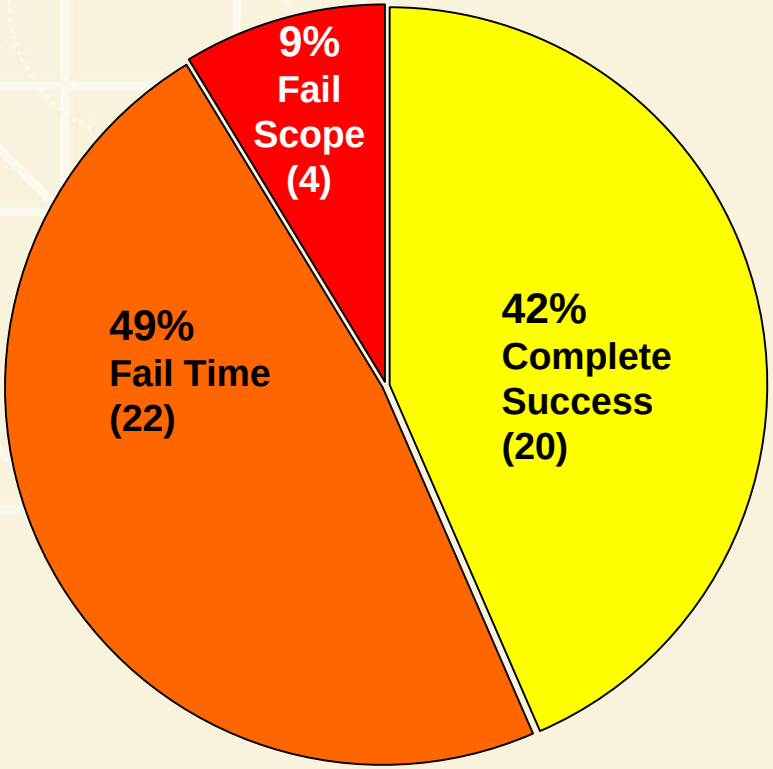
The Normal Projected EHRS Implementation Project Rate for Success/Partial Success/Failure)



EHRS implementation projects are usually abandoned because of project cost overruns. Since the providers are using grant dollars for the bulk of the implementation, this is less of a factor.

** "CIO's Guide to Implementing EHRs in the HITECH Era, CHIME, 2010"*

HIT Supplement Grantee Scenario
No Grantee Will Fail to Implement an EHRS!



Some grantees will not be able to meet the ePrescribing requirement because they do not have any prescribers. They will still be able to enter medications information but technically, they will have failed the scope constraint.

References

1) Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press, 2001.

2) Institute of Medicine. To err is human: building a safer health system. Washington, DC: National Academy Press, 2000.

3) United Stated Department of Health and Human Services. Strategic Plan: Fiscal Years 2010-2015. Retrieved August 2012 http://www.hhs.gov/secretary/about/priorities/strategicplan2010-2015.pdf

4) United Stated Department of Health and Human Services. News release "We Can't Wait: Obama Administration takes new steps to encourage doctors and hospitals to use health information technology to lower costs, improve quality, create jobs" November 30, 2011. Retrieved August 2012 http://www.hhs.gov/news/press/2011pres/11/20111130a.html

5) Agency for Healthcare Research and Quality. Reducing and Preventing Adverse Drug Events to Decrease Hospital Costs. Research in Action, Issue 1. March, 2001. Retrieved August 2012 http://www.ahrq.gov/qual/aderia/aderia.htm

6) United Stated Department of Health and Human Services, Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; Electronic Health Record Incentive Program- Stage 2; Proposed Rule. Federal Register Vol.77, No.5., March 7, 2012.

7) The Lewin Group for the Division of Laboratory Systems, Centers for Disease Control and Prevention. "Laboratory Medicine: A National Status Report." May, 2008. Retrieved August 2012 https://www.futurelabmedicine.org/pdfs/2007%20status%20report%20laboratory_medicine_-_a_national_status_report_from_the_lewin_group.pdf

8) National Transitions of Care Coalition. Position Paper "Improving Transitions of Care with Health Information Technology." December, 2010. Retrieved August 2012 from http://www.ntocc.org/Portals/0/PDF/Resources/HITPaper.pdf

9) National Center for Health Statistics, Centers for Disease Control and Prevention. Data brief "Physician Adoption of Electronic Health Record Systems: United States 2011." July, 2012. Retrieved August 2012 http://www.cdc.gov/nchs/data/databriefs/db98.htm

10) National Council for Community Behavioral Healthcare. Report "HIT Adooption and Readiness for Meaningful Use in Community Behavioral Health: Report on the 2012 National Council Survey." June, 2012. Retrieved August 2012 http://www.thenationalcouncil.org/galleries/business-practice%20files/HIT%20Survey%20Full%20Report.pdf

HIE Supplement Update

HIE Supplement

- Coordination with other Federal Programs & Initiatives
- Coordinating Activities with
  - HL7 Behavioral Health CCD Workgroup
  - ONC's Standards and Interoperability Framework Transitions of Care Workgroup
  - ONC's Standards and Interoperability Framework Data Segmentation Workgroup
  - ONCs State Health Policy Consortium Project (RTI Initiative) for behavioral health data sharing
    - AL, FL, KY, NE, NM, MI Plus other states
- Other states are also participating: CO; NY; UT

- Awareness of What is Possible Today
- Planning for What Will be Possible in the Future
- Recognize we are in a Transition Period
  - Not all 42 CFR conditions can be fully met

Predominant Challenge:

- **Development of a 42 CFR Compliant Consent that is Computable in a HIE Environment**

Our Approach:

- Build on What is Already Developed
- Coordinate with ONC & S&I Workgroups
- Coordinate with SAMHSA
- Ensure Legal Input
  - 3 of 5 HIEs have their legal experts regularly involved on the calls
- Identify current “Better Practices”

- 42 CFR Regs and SAMHSA FAQs 1 and 2 side by side as Consent developed
- HIEs obtained input from their Behavioral Health Workgroups
- HIEs invited their vendors to participate and comment as well
- Everything in "Black" was reviewed and found acceptable by everyone
- "Red" indicates problem areas not yet resolved

(as of 6/29/12 still in process of determining a resolution)

42 CFR Requirements for Consent (SAMHSA FAQs 2010)

A written consent to a disclosure under the Part 2 regulations must be in writing and include all of the following items (42 CFR § 2.31):

1) the specific name or general designation of the program or person permitted to make the disclosure;
2) the name or title of the individual or the name of the organization to which disclosure is to be made;
3) the name of the patient;
4) the purpose of the disclosure;
5) how much and what kind of information to be disclosed;
6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient;
7) the date on which the consent is signed;
8) a statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and
9) the date, event or condition upon which the consent will expire if not revoked before. This data, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

PATIENT CONSENT AND AUTHORIZATION FORM FOR DISCLOSURE OF CERTAIN HEALTH INFORMATION

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____ Date of Birth (mm/dd/yyyy):_____

Address: _____ City: _____ State: _____ Zip:_____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize access, use and disclosure of my:

Check all of the boxes to identify the information you authorize to disclose:

☐ Drug or alcohol abuse treatment information
☐ Mental health treatment information

FROM WHOM: Specific person(s) or organization(s) who I am authorizing to release my information under this form: ☐ **All health care providers involved in my care.** ☐ **All programs in which the patient has been enrolled as an alcohol or drug abuse patient, or** ☐ **Any drug or alcohol treatment program or other health care provider, pharmacy or organization providing care coordination that is affiliated with the XYZ HIO** **Only these providers**			
Person/Organization Name:	**Phone:**	**Address:**	**Secure email address:**

TO WHOM: Specific person(s) or organization(s) permitted to receive my information:

- ☐ **To the HIE [Name]**
- ☐ **The HIE and any provider(s) involved in my care in the HIE as of today's date ONLY**
- ☐ **The HIE and only these specific providers**

Organization Name:	Phone:	Address:	Secure email address:	
ONLY THESE INDIVIDUAL PROVIDERS				**Some HIEs cannot manage only individual providers at this point in time**

Amount and Kind of Information: The information to be released may include but not be limited to: Laboratory, Medications, Medical Care & HIV/Aids, Alcohol & Substance Abuse and Mental or Behavioral Health information		

PURPOSE: The information shared will be used: ☐ **To help with my Treatment and Care Coordination** ☐ **To assist the provider or organization to improve the way they conduct work** ☐ **To help Pay for my Treatment**	**Treatment** **Operations** **Payment**	**ONLY USE WHAT IS APPROPRIATE FOR THE HIE. SOME HIEs ONLY PROVIDE EXCHANGE FOR "TREATMENT"**
EFFECTIVE PERIOD: This authorization/consent/permission form will remain in effect until (enter date, **event or condition** upon which this authorization/consent expires):_____ _____. **If there is no date entered the consent will be valid for one year from the date this form is signed.**		**Best practice is to always ask for a date any date. Events are not computable e.g. how to tell when someone dies. HIE would never know**

<u>REVOKING MY PERMISSION</u>: I can revoke my permission at any time by giving written notice to the person or organization named above in the "To Whom" or "From Whom" sections "except to the extent the disclosure agreed to has been acted on.		

In addition:

- I understand that an electronic copy of this form can be used to authorize the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons according to state or federal law.
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

"This HIE consent does not permit use of my protected health information in any criminal or civil investigation or proceeding against me without an express court order granting the disclosure unless otherwise permitted under state law."

Accept recommended language 5/4/12

X_____ _____

Signature of Patient or Patient's Legal Representative **Date Signed (mm/dd/yyyy)**

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ **Parent of minor**
- ☐ **Guardian**
- ☐ **Other personal representative (explain: _____ _____)**

NOTE: Under some state laws, minors must consent to the release of certain information. The law of the state from which the information is to be released determines whether a minor must consent to the release of the information.

This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Issues/Challenges:

- Some HIEs cannot process only specific providers in the "To Whom" Section
  - Is "All or Nothing"
- Is "All or Nothing" for "Type and Amount" of Data
  - Data Segmentation is not available in all systems today to support Data Segmentation
- HIEs cannot currently process "Only providers in the HIE as of the date of signing the form"
  - Barriers due to technology, cost & operational issues for HIEs and providers

Possible Solutions:

- Use DIRECT only with a Provider Locator Service provided and supported by the HIE
  - Can work in an HIE that is not storing any data and just providing the "pipes" e.g. IL HIE
- Other solutions are in development

Possible Solutions:

- Bring behavioral health data into the HIE but do not "render" it to the provider until the provider has attested with a second sign on that they have a treating relationship with the patient
  - 4 of the 5 HIEs do require this attestation
    - All have audit trail capabilities to track access
- Other solutions are in development

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NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

A Life in the Community for Everyone
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Substance Abuse and Mental Health Services Administration

www.integration.samhsa.gov

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